

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: October/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Multidisciplinary Behavioral Chronic Pain Program, 8 hours/day for 5 days/week x 10 days

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization review determinations, 09/06/11, 09/15/11
Record review 06/29/11
Peer review 09/23/11, 02/03/11
Reconsideration request 09/08/11
Preauthorization determination letter 06/01/11
Progress report and request for services 08/24/11
Functional capacity evaluation 08/19/11
Mental health behavioral assessment 05/23/11
Handwritten progress notes, 08/10/11, 07/20/11, 06/22/11, 05/25/11, 08/11/11, 07/28/11, 06/27/11, 06/20/11, 06/06/11
Office visit notes, 09/02/11, 07/28/11, 06/14/11, 05/03/11, 04/19/11, 03/08/11, 01/27/11, 11/18/10, 12/23/10, 12/16/10, 10/21/10, 09/21/10, 09/16/10, 09/30/10, 06/09/11, 09/13/10, 09/10/10, 09/08/10, 09/02/10, 09/01/10, 08/27/10, 08/13/10, 08/11/10
Operative report, 12/18/10
MRI lumbar spine, 10/06/10
MRI right shoulder, 09/17/10
Electrodiagnostic results, 02/28/11
Individual psychotherapy note, 07/18/11
Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xxxx. The patient reported two injuries on this date. First, she was pushed into a wall, and second, she was lifting and moving and reported pain in her neck, low back and right ankle. A peer review report dated 02/03/11 states that treatment to date has included medication management, physical therapy, lumbar epidural steroid injection and diagnostic testing. The reviewing doctor opines that the lumbar MRI results are not related to the compensable injury and are pre-existent ordinary disease of life. No acute lumbar findings were noted as a direct result of the compensable injury. The compensable injury is listed as an acute myofascial cervical, thoracic and lumbar strain, a

right shoulder strain, partial right supraspinatus rotator cuff tendon tear and a right ankle sprain. Mental health behavioral assessment dated 05/23/11 indicates that BDI is 46 and Burns Anxiety Inventory is 79. Diagnoses are major depressive disorder and pain disorder. The patient has undergone a course of individual psychotherapy. A note dated 06/29/11 indicates that she has multiple pre-existing degenerative changes consistent with her age and that her complaints of anxiety and depression are not related to the injury. Functional capacity evaluation dated 08/19/11 indicates that required PDL is light and current PDL is sedentary.

Current medications are listed as Zanaflex, Celebrex, Ultracet, Theragesic cream, Cymbalta and Zolpidem.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Multiple peer reviews have determined that the extent of injury is cervical thoracic and lumbar sprain and strains, and right shoulder sprain and strain. The patient is not currently taking any opioid medication. The records indicate that the patient's Beck scales are exceedingly high; however, there is no indication that the patient has undergone psychometric testing with validity measures to assess the validity of subjective complaints of the patient. Given the current clinical data, the requested Multidisciplinary Behavioral Chronic Pain Program, 8 hours/day for 5 days/week x 10 days is not indicated as medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)